

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019152

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2519

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

FILED MAY 31 1962

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
J. M. Haight

USE BLACK INK

OR

TYPEWRITER RIBBON

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 35 Yrs	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Josephs Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle M. Last Wells		4. DATE OF DEATH Month May Day 7 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1872
9. AGE (last birthday) 89 Yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (City and state or country) Ladoga Indiana		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME George Watkins		13b. MOTHER'S MAIDEN NAME Laura Kelsey	
14. NAME OF HUSBAND OR WIFE Frank P. Wells		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address Dorothea Kelley 6640 Flora K.C., Mo.	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Vascular Hemorrhage DUE TO (c) Hypertensive Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Semblity PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 3-7-62 to 5-7-62 and last saw her alive on 5-7-62 Death occurred at 5:15 pm m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) J. M. Haight	
22b. ADDRESS 3401 E 12th KC Mo		22c. DATE SIGNED 5-8-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-9-62	
23c. NAME OF CEMETERY OR CREMATORY Pilot Grove		23d. LOCATION (City, town, or county) Jamesport Missouri	
24. FUNERAL DIRECTOR Stine & McClure Kansas City, Missouri		25. DATE RECD. BY LOCAL REG. 5-8-62	
26. REGISTRAR'S SIGNATURE Keith Long			

(Licensed Embalmer's Statement on Reverse Side)

Dr. J. M. Knight
3401 E 12th
Be 1-4822
11:00 - 5:00

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas A. Kachler

Licensed Embalmer No. 4995

P. O. Address H.C., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.